No. 09-696

In the Supreme Court of the United States

JOHN J. KANE REGIONAL CENTERS – GLEN HAZEL,
Petitioner

v.

SARAH GRAMMER, AS ADMINISTRATRIX OF THE ESTATE OF MELVINTEEN DANIELS,
Respondent

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THIRD CIRCUIT

BRIEF OF THE STATES OF PENNSYLVANIA, ALABAMA, ARKANSAS, DELAWARE, IDAHO, INDIANA, LOUISIANA, MICHIGAN, MISSISSIPPI, NEVADA, NEW JERSEY, OKLAHOMA, UTAH, and WYOMING AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

THOMAS W. CORBETT, JR.
Attorney General of Pennsylvania

CALVIN R. KOONS*
Senior Deputy Attorney General
**Counsel of Record*

[Additional Counsel on Inside Cover]

JOHN G. KNORR, III
Chief Deputy Attorney General
Chief, Appellate Litigation Section

Office of Attorney General
Appellate Litigation Section
15th Fl., Strawberry Square
Harrisburg, PA 17120
(717) 783-6709

TROY KING
Attorney General of Alabama
500 Dexter Avenue
Montgomery, AL 36130

DUSTIN MCDANIEL
Attorney General of Arkansas
323 Center Street
Little Rock, AR 72201

JOSEPH R. BIDEN, III
Attorney General of Delaware
Carvel Building
820 N. French Street
Wilmington, DE 19801

LAWRENCE G. WASDEN
Attorney General of Idaho
P.O. Box 83720
Boise, ID 83720-0010

GREGORY F. ZOELLER
Attorney General of Indiana
302 W. Washington Street
IGC-South, Fifth Floor
Indianapolis, IN 46204

JAMES D. "BUDDY" CALDWELL
Attorney General of Louisiana
P.O. Box 94005
Baton Rouge, LA 70804-9005

MICHAEL A. COX
Attorney General of Michigan
P.O. Box 30212
Lansing, MI 48909

JIM HOOD
Attorney General of Mississippi
P.O. Box 220
Jackson, MS 39205

CATHERINE CORTEZ MASTO
Attorney General of Nevada
100 North Carson Street
Carson City, NV 89701

ANNE MILLGRAM
Attorney General of New Jersey
Hughes Justice Complex
P.O. Box 080
25 Market Street
Trenton, NJ 08625

W.A. DREW EDMONDSON
Attorney General of Oklahoma
313 N.E. 21st Street
Oklahoma City, OK 73105-4894

MARK L. SHURTLEFF
Attorney General of Utah
Utah State Capitol, Suite #230
P.O. Box 142320
Salt Lake City, UT 84114-2320

BRUCE A. SALZBURG
Attorney General of Wyoming
123 State Capitol
Cheyenne, WY 82002

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INTEREST OF THE *AMICI CURIAE*

The decision of the Court of Appeals holds that amendments to the Medicaid Act, a statute enacted pursuant to Congress' authority to spend money for the general welfare, confers a private cause of action in third party beneficiaries of the spending program – in this case, a resident of a county operated nursing home enforceable pursuant to 42 U.S.C. § 1983. The *amici* are States which participate in a plethora of federal grants and programs enacted by Congress in legislation pursuant to the Spending Clause under statutory provisions that could give rise to private causes of actions under Section 1983, depending upon how interpreted by the courts. Specifically, States operate and supervise nursing homes which admit patients whose care is paid for by Medicaid and are thus subject to the provisions of the Medicaid Act. Pursuant to the concept of sovereign immunity, many States limit or cap their liability for medical malpractice at state-run facilities. In addition, many States limit medical malpractice actions in other ways. The Court of Appeals' decision negates these limits by effectively federalizing medical malpractice actions.[1]

SUMMARY OF ARGUMENT

The Court should review this case because the decision of the court of appeals has the potential, among other things, to interfere with state sovereignty and the ability of the States to reform their tort law with respect to medical malpractice. It

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[1] Counsel of record for all parties received notice at least ten days prior to the due date of the *amici curiae* intention to file the brief.

does so by improperly reading portions of the Medicaid Act, enacted pursuant to Congress' spending authority, so as to authorize a private cause of action in Medicaid patients, enforceable pursuant to 42 U.S.C. § 1983. This decision effectively "federalizes" medical malpractice, and has the potential to undo caps or limits on liability set up by States as an exercise of sovereign immunity, or, more broadly, as tort reform.

REASONS FOR GRANTING THE PETITION

1. The "Spending Clause" of the Constitution provides for "the power to lay and collect taxes, duties, imports and excises, to pay the debts and provide for the common defense and general welfare of the United States." U.S. Const., Art. I, § 8, cl. 1. The petitioner has correctly said that "over the past 28 years several members of this Court have expressed skepticism as to whether Spending Clause legislation establishing requirements for federal-state cooperative programs can create 'rights' enforceable by third-party beneficiaries under § 1983." Petition at 22, citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 18-20 (1981) (typical remedy for States non-compliance with Spending Clause legislation is not private action but action by the Federal Government to terminate funds); *Blessing v. Freestone*, 520 U.S. 329, 349-350 (1997) (Spending Clause legislation is analogous to contractual obligation and allowing suits by "third party beneficiaries of commitments to the Federal Government ... is certainly a vast expansion.") (Scalia, J. concurring, joined by Kennedy, J.); *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S. 644 (2003) ("serious question" whether third

parties may sue to enforce Spending Clause legislation absent an "unambiguously conferred right') *id.* at 683, (Thomas, J. concurring) (proper remedy for failure to comply with conditions imposed by Spending Legislation is termination of funding) *id.* at 675, (Scalia, J. concurring).

The question of whether Spending Clause legislation can ever support a private cause of action not expressly conferred is important to the States because they participate in a multitude of federal programs enacted by Congress pursuant to the Spending Clause. Something of the range of enactments made pursuant to the Spending Clause can be seen just by considering the Court's jurisprudence concerning the matter. *See, e.g., Gonzaga University v. Doe*, 536 U.S. 273 (2002) (Family Educational Rights and Privacy Act); *Blessing v. Freestone*, 520 U.S. 329 (1997) (Title IV-D of the Social Security Act requiring States to establish child support enforcement units); *Wright v. City of Roanoke Redevelopment and Housing Authority*, 479 U.S. 418 (1987) (United States Housing Act, 42 U.S.C.A. § 1437a); *Suter v. Artist M.*, 503 U.S. 347 (1992) (Adoption Assistance and Child Welfare Act); *Forest Grove School District v. T.A.*, 129 S.Ct. 2484 (2009) (Individuals with Disabilities Education Act); *U.S. v. American Library Ass'n. Inc.*, 539 U.S. 194 (2003) (Children's Internet Protection Act). Of course, these are just a few examples of a legislative power exercised by Congress all the time, and in the widest variety of contexts.

If States are to be liable in private suits for damages based on their failure to adhere to federal conditions on federal spending, it would have a

considerable impact on state treasuries, unforeseeable by the States when they agreed to participate in these programs, and the Court for this reason should consider whether legislation enacted solely pursuant to the Spending Clause can ever support a private cause of action not expressly conferred.

2. The facts of the case presented in the petition and petitioner's second question for certiorari aptly demonstrate this potential impact on state treasuries and on state law. This question asks the Court to review the court of appeals' construction of the Federal Nursing Home Reform Amendments, 42 U.S.C. § 1396a(a)(28), § 1396r (FNHRA) as supporting a private cause of action. The court of appeals held that the family of a woman who died in a county nursing home could sue the home under Section 1983 for its failure to conform to the FNHRA. In pertinent part, the FNHRA requires that States develop a plan to require participating institutions to provide "medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident," "dietary services that assure that the meals meet the daily nutritional and dietary needs of each resident," and "an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial wellbeing of each resident." All this is to be in accordance with each resident's "written plan of care."[2] 42 U.S.C. § 1396r. A provider that fails to

[2] Petitioner cites other statutory provisions that delineate administrative responsibilities, forbid abuse, corporal punishment, restraint under certain circumstances, and unnecessary administration of psychotropic drugs. *See* Petition at 6-7.

comply with these requirements faces a range of sanctions, including not only termination from the Medicaid program, but closure of the facility and transfer of patients, depending on the severity of the violation. 42 U.S.C. § 1396r(h); 42 C.F.R. 488.406.

The State plan is to provide that "any nursing facility, receiving payments under such plan . . . satisfy all the requirements of subsection(b) through (d) of section 1396r of this title as they apply to such facilities." 42 U.S.C. § 1396a(a)(28)(A). State agencies, such as Pennsylvania's Department of Public Welfare survey the single state agency responsible for administering Pennsylvania's Medicaid program in compliance with these requirements. The Department of Health surveys nursing facilities participating in the Program to monitor their compliance with conditions of participation imposed by the FNHRA. Absent substantial compliance, a State may not receive federal matching funds for Medicaid payments made to noncompliant facilities.

As petitioner has pointed out, the requirements of the FNHRA for participation in Medicaid were read by the Court of Appeals to create a cause of action under Section 1983 that is virtually indistinguishable from a state law medical malpractice action. This decision is incorrect as a matter of simple statutory construction because the court of appeals placed too much emphasis on its own precedent, *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004), which interpreted the Medicaid Act, and not enough on the text of the statute itself and on this Court's own precedents. In this respect, the dissenting judge had it right when he wrote, "Whatever *Sabree* may say

about Section 1396a, I do not agree that Congress intended to confer upon nursing home residents the right to invoke Section 1983 to sue individual nursing homes for alleged violations of the non-monetary service requirements set forth in Section 1396r." Pet. App. 28a (Stafford, J., dissenting). Judge Stafford is correct because the statutory language quoted above, relied upon by the majority, is broad and aspirational, and focuses on the state plan regarding the homes regulated rather than the individual patient. The court of appeals made the same mistake it did in *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981). In that case, the Court rejected the notion that a patients' "bill of rights" provision in the Developmentally Disabled Assistance and Bill of Rights Act created substantive rights in patients, and concluded that the Act, despite these provisions, was no more than a "typical funding statute," *id.* at 22, and in *Gonzaga*, the Court quoting *Pennhurst*, said that "[u]nless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement under § 1983." 536 U.S. at 280. The language of the FNHRA does not demonstrate a clear intent to confer rights on individuals any more than the statutory language in *Pennhurst* did.

The issue is important to Pennsylvania and other States because it will likely have a significant impact on their treasuries and operations, and on the limits they have placed on medical malpractice actions in other contexts. Although the petitioner is a county-run facility, the Commonwealth of Pennsylvania, like other States, operates through its Department of Public Welfare and Department of Military and

Veterans' Affairs facilities for long term care and other types of facilities that treat Medicaid recipients. As a matter of state law, however, Pennsylvania has chosen to limit its liability in tort. In Pennsylvania, state sovereign immunity is expressly waived as to several classes of cases, "medical professional liability" being one of them, 42 Pa. C.S. § 8522(b), but liability for damages is capped in all cases at $250,000 per plaintiff or $1,000,000 per occurrence, 42 Pa. C.S. § 8528(b).

Most States have limited and/or capped their liability for damages in tort, pursuant to the exercise of sovereign immunity. AGRiP (Association of Governmental Risk Pools) Quick Reference State-by-State Tort Highlights Matrix, http://www.agrip.org/sites/agrip/uploads/documents/Tort_Demo/0609StateTortCapsMatrixForWebsite.xls. More than this, States may limit the immunity of local governments as well as their own and may otherwise limit damages for medical malpractice actions in general. For example, in Pennsylvania, local governments have no liability at all for medical malpractice. 42 Pa. C.S. § 8542. In addition, many States have limited medical malpractice generally, or have imposed special requirements as part of tort reform. For example, in Pennsylvania, plaintiffs in medical malpractice actions must obtain a "certificate of merit" from a physician before they can proceed. Pa. R.C.P. 1042.3. Many States have limited the damages available in medical malpractice actions in general as part of tort reform. *See Impact of State Laws Limiting Malpractice Awards on Geographic Distribution of Physicians, U.S. Dept. of Health & Human Services, Agency for Healthcare Research & Quality*, http://www.ahrq.gov/research/tortcaps/tortcaps.htm.

The Court of Appeals' decision undoes all this. In the first place, it leaves Pennsylvania and other states who have chosen to thus limit their exposure to tort liability, open to medical malpractice-type actions masquerading as federal civil rights claims as to which no limitations on damages apply and which also involves potential attorneys' fees pursuant to 42 U.S.C. § 1988. Although the state and its agencies could not be sued for damages, its employees could, in derogation of the limitations on damages they would otherwise enjoy as state parties. Pennsylvania, provides defense and indemnification for all officials and employees for civil suits brought "in his official or individual capacity for alleged negligence or other unintentional misconduct occurring while in the scope of employment." 39 Pa. Code § 39.2, http://www.pacode.com/secure/data/004/chapter39/s39.2.

This alone is no small matter. Pennsylvania alone directly operates State facilities which include 1,323 nursing facility Medicaid beds. In addition, State personnel "survey" private and county nursing facilities which account for an additional 84,819 beds, to assure that these facilities are in compliance with the conditions of Medicaid participation. It is doubtful that these survey teams could be liable at all under Pennsylvania state law, because their work does not seem to fit clearly within any of the waived categories of cases, yet it does not take much imagination to envision members of survey teams named as defendants in a Section 1983 suit if a nursing facility is accused of malpractice involving a Medicaid patient.

Further, the decision may affect other limits state law places on medical malpractice actions. The Third Circuit's holding not only does away with the limits that States have placed on medical malpractice liability (either for themselves or as part of more general tort reform), it exposes governmental providers to *more* liability than in an ordinary medical malpractice case. Nothing in the statute suggests that Congress intended to treat malpractice by government-run nursing homes more harshly than that by private providers, nor does any reason come to mind why they would. At best, this diverts resources away from patient care: at worst, it creates a disincentive for governments to provide care at all.

These consequences could also extend to private providers. Private providers are not state actors, *see Blum v. Yaretsky*, 457 U.S. 991 (1982), and are not normally liable under Section 1983. But the Third Circuit's holding creates an incentive to plead ordinary medical malpractice claims as "conspiracies" between providers and state officials such as surveyors. *See Tower v. Glover*, 467 U.S. 914 (1984).

The Court has rejected the notion that constitutional guarantees, like the Fourteenth Amendment, should become "a font of tort law superimposed on whatever systems may be administered by the States." *Paul v. Davis*, 424 U.S. 693, 701 (1976), yet this decision effectively does just that. It creates from the Medicaid Act's conditions on the receipt of federal money a cause of action under Section 1983 that is virtually coextensive with one brought as a state law medical malpractice claim, and since it is based on the Spending Clause alone, is untethered from any constitutionally guaranteed

rights as are other constitutional torts. Further, it does so at potentially great economic cost to states that have chosen to limit their liability in this area. The issue is an important one, and the Court should grant the petition.

CONCLUSION

The Court should grant the petition.

Respectfully submitted,

THOMAS W. CORBETT, JR.
Attorney General

JOHN G. KNORR, III
Chief Deputy Attorney General

CALVIN R. KOONS*
Senior Deputy Attorney General
**Counsel of Record*

OFFICE OF ATTORNEY GENERAL
Appellate Litigation Section
15th Floor, Strawberry Square
Harrisburg, PA 17102
(717) 783-6709

Date: 1/15/10